The purpose of this document is to provide services with a clear understanding of the available services within the Cardiology Department and when to refer patients.

**Cardiology Service Delivery**

Cardiology have a consultant led 24/7 service with a ‘home team’ model of care in ward 2D. There are 4 Coronary Care Unit (CCU/CTS) beds for high dependency patients. There is a consultant ward round every day including weekends on all cardiology patients in 2D. The ward round then extends into the Assessment and Planning Unit (APU) to review patients admitted under general medicine who require an urgent cardiology consultation at the request of the consultant general physician on call or consultant in charge of APU.

There is a first on consultant for general cardiology advice and a second on consultant for emergency coronary intervention. There is always a registrar on call in hospital during working hours and on call from home out of hours. Patients presenting with an emergency cardiology problem should initially be assessed and treated by Emergency Department (ED) physicians. Between 8 am and 5 pm the Cardiology Registrar should be contacted first for advice on patients with a preliminary cardiology diagnosis as detailed below. ED physicians should however activate a Code STEMI according to the protocol. Patients without a clear cardiology diagnosis should be referred for review by the general physicians in the first instance. Out of hours most patients should be referred to General Medicine for initial assessment and treatment. The patients should then be admitted under general medical bed card overnight and transferred to Cardiology where appropriate the following morning. This can be facilitated by communication between the overnight General Medicine Team and the Cardiology Registrar at 8 am the following morning. This model of care ensures that the patient is looked after and reviewed by a team of physicians on site overnight in the hospital. The Cardiology Registrar can be contacted for advice on management of the patient. If the patient becomes unstable the cardiology team can be contacted and will come in to review patients if necessary. There is the facility to contact the Consultant Cardiologist on call but usually on a consultant to consultant basis or through the Cardiology Registrar on call.
When to refer to Cardiology

Patients with the following confirmed preliminary diagnosis should be admitted under Cardiology:

**Acute Coronary Syndrome**
- ST segment elevation myocardial infarction (STEMI) in accordance with the protocol
- High risk according to the acute coronary syndrome (ACS) pathway
- Intermediate risk according to the ACS pathway likely to require coronary investigation with a view to intervention within 24hrs
- All other intermediate risk and low risk ACS patients should be admitted under General Medicine to APU

**Heart Failure (Refer to Clinical Presentation Pathway and European Society of Cardiology Guidelines attached)**
- New primary diagnosis of decompensated heart failure without multiple co-morbidities
- Known congestive heart failure (CHF) or pulmonary hypertension under regular cardiology review presenting with decompensated heart failure
- Cardiogenic shock in liaison with the Intensive Care Unit (ICU)
- Cardiac transplant or left ventricular assist device (LVAD) presenting with decompensated heart failure or other significant cardiology problem

**Arrhythmias**
- High grade atroventricular (AV) block
- Symptomatic brady arrhythmia
• Patients with confirmed pacemaker or implantable cardioverter-defibrillator (ICD) malfunction
• Broad complex tachycardia as a primary diagnosis
• Out of hospital cardiac arrest in liaison with ICU
• Patients who have received therapy from an ICD
• Patients with undifferentiated syncope or atrial fibrillation should be initially assessed by General Medicine

**Structural Heart Disease**

• Patients with known structural heart disease e.g. adult congenital heart disease or hypertrophic cardiomyopathy (HOCM) presenting with a significant a cardiology problem
• Patients with confirmed endocarditis in liaison with ID.

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